AMENDED IN SENATE MAY 19, 1999

AMENDED IN SENATE MAY 6, 1999

AMENDED IN SENATE APRIL 26, 1999

SENATE BILL No. 870

Introduced by Senator Vasconcellos

February 25, 1999

An act to amend Sections ~~10231.5,~~ 10232.1, 10232.2, 10232.3, 10232.4, 10232.8, 10232.93, 10233.2, 10234.87, 10234.95, 10235.30, 10235.40, 10235.50, 10235.52, 10237.1, 10237.4, and 10237.5 of, to add Sections 10232.81, 10232.91, 10232.94, and 10235.94 to, to repeal ~~Sections 10231.6 and~~ *Section* 10235.10 of, and repeal and add Sections 10232.92, 10232.95, and 10237.2 of, the Insurance Code, relating to long-term care insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 870, as amended, Vasconcellos. Long-term care insurance.

Existing law prescribes various requirements and conditions governing the delivery or issuance for delivery in this state of individual or group long-term care insurance.

This bill would make various changes to those provisions, including changes clarifying an insurer's obligations to file, offer, and market policies intended to be federally qualified and policies that are not intended to be federally qualified; changes mandating coverage for care in a residential care facility and for respite care; changes relating to coverage for preexisting conditions; changes relating to eligibility for benefits; changes relating to elimination or deductible periods

in every policy or certificate; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies; changes clarifying policy replacements; and changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursements.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Section 10231.5 of the Insurance Code is amended to read:~~

~~10231.5. "Certificate" means any certificate which has been delivered or issued for delivery in this state under a group long-term care insurance policy in or outside this state.~~

~~SEC. 2. Section 10231.6 of the Insurance Code is repealed.~~

~~SEC. 3.~~

SECTION 1. Section 10232.1 of the Insurance Code is amended to read:

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is intended to be a federally qualified long-term care insurance contract and may qualify you for federal and state tax benefits." Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: "This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract."

(b) Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a ''nursing facility and residential care facility only'' policy or certificate and the words ''Nursing Facility and Residential Care Facility Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a ''home care only'' policy or certificate and the words ''Home Care Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(d) Only those policies or certificates providing benefits for both institutional care and home care may be called ''comprehensive long-term care'' insurance.

~~SEC. 4.~~

SEC. 2. Section 10232.2 of the Insurance Code is amended to read:

10232.2. (a) Every insurer that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, shall fairly and affirmatively concurrently file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified, as described in subdivision (a) of Section 10232.1, that contain benefits and coverages similar to policies and certificates that are intended to be federally qualified long-term insurance contracts.

(b) All long-term care insurance contracts, including riders to life insurance contracts providing long-term care coverage, approved after the effective date of this section shall meet all of the requirements of this chapter.

(c) Until January 1, 1999, or 90 days after approval of contracts submitted for approval pursuant to subdivision (b), whichever comes first, insurers may continue to offer

and market previously approved long-term care insurance contracts.

(d) Group policies issued prior to January 1, 1997, shall be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997–98 Regular Session, unless those polices cease to be treated as federally qualified long-term care insurance contracts. If such a policy or certificate issued on such a group policy ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f)(2) of the Internal Revenue Code, the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

~~SEC. 5.~~

SEC. 3. Section 10232.3 of the Insurance Code is amended to read:

10232.3. (a) All applications for long-term care insurance except that which is guaranteed issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant. Each question shall contain only one health status inquiry and shall require only a ‘‘yes’’ or ‘‘no’’ answer, except that the application may include a request for the name of any prescribed medication and the name of a prescribing physician. If the application requests the name of any prescribed medications or prescribing physicians, then any mistake or omission shall not be used as a basis for the denial of a claim or the recision of a policy or certificate.

(b) The following warning shall be printed conspicuously and in close conjunction with the applicant’s signature block:

‘‘Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.’’

(c) Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents which this chapter requires be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include those required by Sections 10232.25 and 10233.5, paragraphs (8) and (9) of subdivision (a) of Section 10234.93, subdivision (c) of Section 10234.95, and Section 10235.16 if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(d) If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall:

(1) Pertain to the condition for which benefits are sought.

(2) Involve a chronic condition or involve dates of treatment before the date of application.

(3) Be material to the acceptance for coverage.

(e) No long-term care policy or certificate may be field issued.

(f) The contestability period as defined in Section 10350.2 for long-term care insurance shall be two years.

(g) A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate.

(h) Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured, and shall annually furnish this information to the commissioner in a format prescribed by the commissioner.

~~SEC. 6.~~

SEC. 4. Section 10232.4 of the Insurance Code is amended to read:

10232.4. (a) No long-term care insurance policy or certificate other than a group policy or certificate, as described in subdivision (a) of Section 10231.6, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) Every long-term care insurance policy or certificate shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

(c) The commissioner may extend the limitation periods set forth in subdivisions (a) and (b) as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (b) expires. Unless such waiver or rider has been specifically approved by the commissioner, no long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (b).

~~SEC. 7.~~

SEC. 5. Section 10232.8 of the Insurance Code is amended to read:

10232.8. (a) In every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as the following provisions:

''HOW TO QUALIFY FOR BENEFITS:

We will pay for the long-term care services covered by this policy (certificate) when one of the following criteria is met:

(1) You are unable to perform, without standby assistance or hands-on assistance from another individual, two out of seven activities of daily living due to a loss of functional capacity, or

(2) You have a cognitive impairment.

The definitions for the following terms will help explain how you qualify for benefits under this policy:

(A) Activities of daily living.

(B) Standby assistance.

(C) Hands-on assistance.

(D) Cognitive impairment.

(E) Qualified long-term care services.''

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

''Activities of daily living'' in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits shall include eating, bathing, dressing, ambulating, transferring, toileting, and continence.

The following definitions shall be used verbatim to define eligibility for benefits in policies or certificates that are not intended to be federally qualified long-term care insurance:

(1) ''Standby assistance'' means the presence of another person within arm's reach of you that is necessary

to prevent, by physical intervention, injury to you while you are performing an activity of daily living, such as being ready to catch you if you fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from your throat if you choke while eating.

(2) ''Hands-on assistance'' means the physical assistance of another person without which you would be unable to perform the activity of daily living.

(3) Cognitive impairment means a deterioration or loss of intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(4) ''Long-term care services'' means necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are needed to assist you with the disabling conditions that cause your loss of functional capacity. ''Maintenance or personal care services'' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities resulting from your loss of functional capacity, including the protection from threats to health and safety due to severe cognitive impairment.

(b) Every long-term care policy approved or certificate issued after the effective date of the act adding this section, that is intended to be a federally qualified long-term care insurance contract as described in subdivision (a) of Section 10232.1, shall establish the threshold for eligibility for home care benefits as follows:

(1) The policy or certificate shall include a provision, to be used verbatim unless modified by regulation as provided in paragraph (2), as follows:

''HOW TO QUALIFY FOR BENEFITS:

We will pay for the qualified long-term care services covered by this policy (certificate) if:

(A) You are a chronically ill individual; and

(B) The qualified long-term care services are prescribed for you in a written plan of care.

You will be considered a chronically ill individual when one of the following criteria is met:

(A) You are unable to perform, without standby assistance or hands-on assistance from another individual, two activities of daily living due to a loss of functional capacity and this loss of functional capacity is expected to last at least 90 days.

(B) You have a severe cognitive impairment requiring substantial supervision to protect you from threats to health and safety.

The certification that you are a chronically ill individual must be made by a licensed health care practitioner, independent of us, within the preceding 12 months and must be renewed at least every 12 months. The services to be paid by this policy must be prescribed in a written plan of care prepared by a licensed health care practitioner, independent of us, after a face-to-face assessment of your long-term care needs.

All services covered by this policy are qualified long-term care services.

The definitions for the following terms will help explain how you qualify for benefits under this policy:

Activities of daily living.

Standby assistance.

Hands-on assistance.

Severe cognitive impairment.

Substantial supervision.

Licensed health care practitioner.

Plan of care.

Qualified long-term care services.''

(2) Other criteria shall be used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner shall promulgate emergency regulations to add those other criteria as a third threshold to establish eligibility for benefits. Insurers shall submit policies for approval within 60 days of the effective date of the regulations. With respect to

policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation shall include the third criterion. No policy shall be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion shall be eligible for benefits regardless of whether the individual meets benefit eligibility requirements of paragraph (1).

(c) A licensed health care practitioner, independent of the insurer, shall certify that the insured meets the definition of ''chronically ill individual'' as defined under Public Law 104-191. In the event a health care practitioner makes a determination, pursuant to this section, that an insured does not meet the definition of ''chronically ill individual,'' the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured. The assessments conducted pursuant to this section shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months. A licensed health care practitioner, independent of the insurer, shall develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of ''chronically ill individual,'' or to prepare written plans of care shall not count against the lifetime maximum of the policy or certificate. In order to be considered ''independent of the insurer,'' a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification. It is the intent of this

subdivision that the practitioner's assessments be unhindered by financial considerations. This subdivision shall apply only to a policy or certificate intended to be a federally qualified long-term insurance contract.

(d) ''Activities of daily living'' in every policy or certificate intended to be a federally qualified long-term care insurance contract as provided by Public Law 104-191 shall include eating, bathing, dressing, transferring, toileting, and continence.

(e) The definitions of ''activities of daily living'' to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

(1) Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(2) Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

(3) Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

(4) Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(5) Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.

(6) Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

The commissioner may approve the use of definitions of ''activities of daily living'' that differ from the verbatim definitions of this subdivision if these definitions would result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions of this subdivision. In addition, the following definitions may be used without the

approval of the commissioner: (1) the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence in subdivision (g); or (2) the verbatim definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of ''transferring'' as follows: ''transferring,'' which shall mean the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is (1) warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and (2) strictly limited to that language which is necessary to ensure that the definitions required by this section are not misleading to the insured.

~~(f) Until the time that these definitions may be superseded by federal law or regulation, the following~~

(f) The following definitions shall be used verbatim to define eligibility for benefits in policies and certificates intended to be federally qualified long-term care insurance~~:~~ *unless the definitions conflict with federal law or regulations. In the event of a conflict between these definitions and federal law or regulations, the federal law or regulations shall govern.*

(1) ''Standby assistance'' means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, injury to you while you are performing an activity of daily living, such as being ready to catch you if you fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from your throat if you choke while eating.

(2) ''Hands-on assistance'' means the physical assistance of another person without which you would be unable to perform the activity of daily living.

(3) ''Severe cognitive impairment'' means a loss or deterioration in intellectual capacity that:

(A) Is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia; and

(B) Is measured by clinical evidence and standardized tests that reliably measure impairment in the person's short-term or long-term memory, orientation as to people, places, or time, and deductive or abstract reasoning.

(4) ''Substantial supervision'' means continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations, by another person that is necessary to protect a person who has severe cognitive impairment from the threats to his or her health or safety, as may result from wandering.

(5) ''Licensed health care practitioner'' means any physician, as defined in Section 1861 of the Social Security Act, and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

(6) ''Plan of care'' means a written individualized plan of services prescribed by a licensed health care practitioner, which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual, and the cost, if any, of any formal long-term care services prescribed. Changes in the plan of care must be documented to show that these alterations are required by changes in the client's medical situation, functional, or cognitive abilities, behavioral abilities, or the availability of social supports.

(7) ''Qualified long-term care services'' means necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are needed to assist you with the disabling conditions that cause you to be a chronically ill individual. ''Maintenance or personal care services'' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a chronically ill individual, including the protection from

threats to health and safety due to severe cognitive impairment.

(g) The definitions of ‘‘activities of daily living’’ to be used verbatim in policies and certificates that are not intended to qualify for favorable tax treatment under Public Law 104-191 shall be the following:

(1) Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

(2) Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

(3) Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

(4) Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(5) Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

(6) Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

(7) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

~~SEC. 10.~~

SEC. 6. Section 10232.81 is added to the Insurance Code, to read:

10232.81. (a) The elimination or deductible period in every policy or certificate may not be more restrictive than the following:

(1) Each day on which a service covered by the policy or certificate is received and paid for by the policy or certificate holder or paid on behalf of the policy or certificate holder by Medicare, other insurance, or any other third party, shall count toward meeting the elimination period of the policy or certificate.

(2) Each day on which a service covered by the policy or certificate but paid by the insured or any other party is received prior to or after the filing of a claim for benefits shall count toward meeting the elimination period if the insured can establish the benefit eligibility criteria of the policy or certificate was met before the claim was filed.

(3) The insured may not be required to meet more than one elimination or deductible period.

(4) In the event the existing coverage is increased as provided by Section 10235.51 or the existing coverage is converted to, or replaced by, a new or other policy or certificate issued by the same insurer, the insured shall not be required to meet a new elimination or deductible period if the elimination or deductible period of the existing or previous policy or certificate has been met.

(5) Any day on which the insured received paid care covered by the policy during a period no less than two years prior to the filing of a claim for benefits must be counted toward meeting the elimination or deductible requirements of the policy or certificate.

(b) Respite care, if paid by the policy or certificate prior to meeting the elimination or deductible period of the policy or certificate, is not required to be counted toward meeting the elimination or deductible period.

~~SEC. 11.~~

SEC. 7. Section 10232.91 is added to the Insurance Code, to read:

10232.91. Every long-term care policy or certificate shall include a respite care benefit with the following features:

(a) No less than 21 days of care must be covered in each policy year.

(b) Eligibility shall be at least as permissive as the criteria of Section 10232.8.

(c) No elimination or waiting period shall apply.

(d) The same benefits and benefit amounts must be payable for any home and community-based services defined in Section 10232.9, assisted living benefit defined in Section 10232.92, or institutional care covered by the policy or certificate.

~~SEC. 12.~~

SEC. 8. Section 10232.92 of the Insurance Code is repealed.

~~SEC. 13.~~

SEC. 9. Section 10232.92 is added to the Insurance Code, to read:

10232.92. Every long-term care policy or certificate and every benefit covering institutional confinement shall also include a provision with the following features:

(a) Care in a residential care facility must be covered. ‘‘Residential care facility’’ means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, eligible providers are facilities that are licensed by the appropriate state agency where licensure is required or, if no licensure is required, facilities that are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

(b) The benefit amount payable for care in a residential care facility shall be no less than 70 percent of the benefit amount payable for institutional confinement.

(c) All expenses incurred by the insured while confined in a residential care facility shall be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate. There shall be no restriction on who may provide the service or the requirement that services be provided by the residential care facility, and no restriction on the type of service, supply, or expenses incurred that are covered or the amounts that are reimbursable as long as the expenses are incurred while the insured is confined in a residential care facility and the reimbursement does not exceed the maximum daily residential care facility benefit of the policy or certificate.

(d) In policies or certificates that are not intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be the same as for home care benefits, as defined in subdivision (a) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment of cognitive ability shall be the same as for home care benefits, as defined in subdivisions (a) and (g) of Section 10232.8. In policies or certificates that are intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be the same as for home care benefits, as defined in subdivision (b) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment in cognitive ability shall be the same as those for home care benefits as defined in subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

~~SEC. 14.~~

SEC. 10. Section 10232.93 of the Insurance Code is amended to read:

10232.93. Every long-term care policy or certificate shall define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services defined in Section 10232.9, assisted living benefit defined in Section 10232.92,

or institutional care covered by the policy or certificate. There shall be no limit on any specific covered benefit or the reimbursable amount for any provider except for a daily, weekly, or monthly limit set for home- and community-based care and for assisted living care, and for the limits for institutional care. Nothing in this section shall be construed as prohibiting limitations for reimbursement of actual expenses and incurred expenses up to daily, weekly, and monthly limits.

~~SEC. 14.5.~~

SEC. 11. Section 10232.94 is added to the Insurance Code, to read:

10232.94. Every policy or certificate shall include a provision to waive the premium after no more than 30 days of confinement in a residential care or nursing facility. A pro rata refund of the prior premium shall also be made.

~~SEC. 15.~~

SEC. 12. Section 10232.95 of the Insurance Code is repealed.

~~SEC. 16.~~

SEC. 13. Section 10232.95 is added to the Insurance Code, to read:

10232.95. (a) In every long-term-care policy or certificate that covers institutional care the threshold establishing eligibility for institutional care shall be no more restrictive than a provision that the insured will qualify if either one of two criteria are met:

(1) Impairment in two activities of daily living.

(2) Impairment in cognitive ability.

(b) A provision shall be included that all expenses incurred by the insured while confined in a nursing facility shall be covered and payable, up to the maximum daily facility benefit of the policy or certificate. There shall be no restriction on who may provide the service or the requirement that services be provided by the nursing facility, and no restriction on the type of service, supply, or expenses incurred that are covered or the amounts that are reimbursable as long as the expenses are incurred while the insured is confined in a nursing facility and the

reimbursement does not exceed the maximum daily nursing facility benefit of the policy or certificate.

~~SEC. 17.~~

SEC. 14. Section 10233.2 of the Insurance Code is amended to read:

10233.2. Long-term care insurance may not:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(d) Limit or deny benefits to a policyholder or certificate holder diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, mental illness without demonstrable organic disease, progressive, degenerative, and dementing illnesses, including, but not limited to, Alzheimer's disease. Where a particular disease can be determined only with an autopsy, ''diagnosed'' means clinical diagnosis as specified in Section 10123.16. The requirements of this subdivision do not modify any preexisting condition or underwriting standards and do not preclude or limit underwriting in accordance with an insurer's established underwriting standards. On and after July 1, 1989, any outline of coverage used in connection with long-term care insurance coverage issued in this state shall include or have attached thereto a statement in positive terms, to the effect that the coverage described and required by this subdivision is provided. That statement shall describe the coverage and not merely make reference to this subdivision.

(e) Provide for payment of benefits based on a standard described as ‘‘usual and customary,’’ ‘‘reasonable and customary,’’ or words of similar import.

(f) Describe the insurer’s willingness to consider a policy or certificate holder request to pay for benefits not otherwise covered under the policy or certificate as a benefit nor include language that could mislead the policy or certificate holder to expect the insurer will easily or routinely approve such a request. Any alternative payment provision shall clearly state that the approval of a request for payment of benefits, not otherwise covered, is solely at the discretion of the insurer and is not likely to be granted unless the insurer determines the alternative service is appropriate and a cost-effective alternative to the benefits covered by the policy or certificate.

(g) Contain a restoration of benefit or similar provision that restores the lifetime maximum benefit or the maximum on any other covered benefit, unless the provision allows for the full restoration of the lifetime maximum benefit and other benefit maximums after a period no longer than six months from the date the insured ceased to use benefits covered by the policy or certificate. ‘‘Full restoration’’ means the benefit maximums shall be restored to the amounts that would otherwise have been payable, including an adjustment due to an inflation protection feature, if the insured had not used any covered benefits.

(h) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.

(i) Provide for a lesser level of reimbursement if the policyholder or certificate holder chooses not to use a provider or service selected by the insurer.

(j) Include additional benefits, other than the statutorily required home- and community-based service benefits in Section 10232.9, the assisted living benefit in Section 10232.92, or a nursing facility benefit, unless the additional benefit provides for the payment of a

reasonable percentage of the actual cost of the additional covered service.

~~SEC. 18.~~

SEC. 15. Section 10234.87 of the Insurance Code is amended to read:

10234.87. (a) Every policy or certificate shall include a provision that if the insurer replaces a policy or certificate that it has previously issued, the insurer shall recognize past insured status by granting premium credits toward the premiums for the replacement policy or certificate. The premium credits shall equal five percent of the annual premium of the prior policy or certificate for each full year the prior policy or certificate was in force. The premium credit shall be applied toward all future premium payments for the replacement policy or certificate, but the cumulative credit allowed need not exceed 50 percent. No credit need be provided if a claim has been filed under the original policy or certificate. The premium credit, if any, shall be shown on the application and on the policy or certificate.

(b) The cumulative credits allowed need not reduce the premium for the replacement policy or certificate to less than the premium of the original policy or certificate.

(c) A replacement policy or certificate shall be issued with the same benefit coverage amounts as those in force in the policy or certificate being replaced, after adjustment for increases due to any inflation protection features. The premium for the replacement policy or certificate will be calculated based on the amount of coverage in force at the time the policy or certificate being replaced was issued, the current attained age of the insured, and a premium discount in recognition of past insured status as provided in subdivision (a).

(d) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

~~SEC. 18.5.~~

SEC. 16. Section 10234.95 of the Insurance Code is amended to read:

10234.95. (a) Every insurer or other entity marketing long-term care insurance shall:

(1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant.

(2) Train its agents in the use of its suitability standards.

(3) Maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(b) The agent and insurer shall develop procedures that take into consideration, when determining whether the applicant meets the standards developed by the insurer, the following:

(1) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage.

(2) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs.

(3) The value, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.

(c) The issuer, and where an agent is involved, the agent, shall make reasonable efforts to obtain the information set out in subdivision (b). The efforts shall include presentation to the applicant, at or prior to application, of the ''Long Term Care Insurance Personal Worksheet,'' contained in the most current Long Term Care Insurance Model Regulations of the National Association of Insurance Commissioners. The personal worksheet used by the insurer shall contain, at a minimum, the information in the NAIC worksheet in not less than 12-point type. In the ''Premium Section'' of the personal worksheet, the insurer shall disclose all rate increases and rate increase requests for any prior policies it has sold in any state. The insurer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed and approved by the commissioner.

(d) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sale of employer group long-term care insurance to employees and their spouses and dependents.

(e) The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet is prohibited.

(f) The issuer shall use the suitability standards it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(g) Agents shall use the suitability standards developed by the insurer in marketing long-term care insurance.

(h) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. Alternatively, the issuers shall send the applicant a letter similar to the ''Long-Term Care Insurance Suitability Letter'' contained in the Long-Term Care Model Regulations of the National Association of Insurance Commissioners. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(i) The insurer shall report annually to the commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number who chose to conform after receiving a suitability letter.

(j) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

~~SEC. 19.~~

SEC. 17. Section 10235.10 of the Insurance Code is repealed.

~~SEC. 20.~~

SEC. 18. Section 10235.30 of the Insurance Code is amended to read:

10235.30. (a) No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period nonforfeiture benefit with the following features:

(1) Eligibility begins no later than after 10 years of premium payments.

(2) The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy.

(3) The same benefits are payable, including the amounts and frequency in effect at the time of lapse, for a qualifying claim.

(4) The lifetime maximum benefit may be reduced by the amount of any claims already paid.

(5) Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.

(6) The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

(b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

~~SEC. 20.5.~~

SEC. 19. Section 10235.40 of the Insurance Code is amended to read:

10235.40. (a) No individual long-term care policy or certificate shall be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1) A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse

or termination of the policy or certificate for nonpayment of premium.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read as follows:

''Protection Against Unintended Lapse.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

_____ _____

Signature of Applicant Date''

(b) The insurer shall notify the insured of the right to change the written designation, no less often than once every two years.

(c) When the policyholder or certificate holder pays the premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision (a) need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified long-term care insurance policy or certificate shall clearly indicate the deduction payment plan selected by the applicant.

(d) No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States certified mail, postage prepaid, with a return

receipt indicating proof of delivery to be signed by the insured or individuals designated pursuant to subdivision (a), not less than 30 days after a premium is due and unpaid.

(e) Each long-term care insurance policy or certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

~~SEC. 21.~~

SEC. 20. Section 10235.50 of the Insurance Code is amended to read:

10235.50. Every policy or certificate shall include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower premiums:

(a) A right, exercisable any time after the first year, to retain a policy or certificate while lowering the premium in no fewer than the following three ways:

(1) Reducing the lifetime maximum benefit.

(2) Reducing the nursing facility per diem and reducing the home- and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.

(3) Converting a ''comprehensive long-term care'' policy or certificate to a ''Nursing Facility Only'' or a ''Home Care Only'' policy or certificate, if the insurer issues those policies or certificates for sale in the state.

(b) The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date.

(c) If the contract in force at the time a reduction in coverage is made provides for benefit adjustments for anticipated increases in the costs of long-term care services, then the reduced nursing facility per diem, lifetime maximum benefit, and daily, weekly, or monthly home care benefits shall be adjusted in the same manner and in the same amount as the contract in force prior to the reduction in coverage.

(d) In the event a policy or certificate is about to lapse, the insurer shall provide written notice to the insured of the options in subdivision (a) to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options. The insurer may include in the notice additional options to those required in subdivision (a). The notice shall provide the insured at least 30 days in which to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects the reduced coverage.

(e) In the event of a premium increase, the insured shall be offered the option to lower premiums and reduce coverage.

~~SEC. 22.~~

SEC. 21. Section 10235.52 of the Insurance Code is amended to read:

10235.52. (a) Every policy shall contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of its policies who are not in benefit or within the elimination period the following rights:

(1) The policyholder will be notified of the availability of the new benefits or benefit eligibility or new policy within 12 months. The insurer’s notice shall be filed with the department at the same time as the new policy or rider.

(2) The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways:

(A) By adding a rider to the existing policy and paying a separate premium for the new benefit or benefit

eligibility based on the insured's attained age. The premium for the existing policy will remain unchanged based on the insured's age at issuance.

(B) By replacing the existing policy or certificate in accordance with Section 10234.87.

(C) By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.

(b) The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate.

(c) The insurer of a group policy as defined under subdivisions (a) to (c), inclusive, of Section 10231.6 must offer the group policyholder the opportunity to have the new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the issuer's offer.

~~SEC. 23.~~

SEC. 22. Section 10235.94 is added to the Insurance Code, to read:

10235.94. Every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments.

~~SEC. 24.~~

SEC. 23. Section 10237.1 of the Insurance Code is amended to read:

10237.1. No insurer may deliver or issue for delivery a long-term care insurance policy or certificate in this state unless the insurer offers to each policyholder and certificate holder, in addition to any other inflation protection, the option to purchase a long-term care insurance policy or certificate that provides for benefit levels and benefit maximums to increase to account for reasonably anticipated increases in the costs of long-term

care services covered by the policy. Insurers shall offer to each policyholder and certificate holder, at the time of purchase, the option to purchase a long-term care insurance policy or certificate containing an inflation protection feature which is no less favorable than one that does one or more of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5 percent.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status and without regard to claim status or history so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.

~~SEC. 25.~~

SEC. 24. Section 10237.2 of the Insurance Code is repealed.

~~SEC. 26.~~

SEC. 25. Section 10237.2 is added to the Insurance Code, to read:

10237.2. The inflation protection feature, if any, that applies to the benefit levels and benefit maximum of the policy or certificate shall also apply to the benefit levels and benefit maximums of any rider or amendments issued in conjunction with the policy or certificate.

~~SEC. 27.~~

SEC. 26. Section 10237.4 of the Insurance Code is amended to read:

10237.4. (a) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured’s age, claim status or claim

history, or the length of time the person has been insured under the policy.

(b) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(c) The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature shall not be reduced due to the payment of claims.

~~SEC. 28.~~

SEC. 27. Section 10237.5 of the Insurance Code is amended to read:

10237.5. (a) An inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(b) The rejection, to be included in the application or on a separate form, shall state:

''I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

_____ _____

Signature of Applicant Date''

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